CALIFORNIA HEALTH ADVOCATES

When Your Part D Prescription is Denied

Medicare beneficiaries in a Part D prescription drug plan, whether a stand-alone plan or a Medicare Advantage plan with a prescription drug benefit, have certain rights, including the right to:

- Request coverage determinations;
- Request exceptions;
- File appeals; and
- File grievances.

Please refer to your plan's Evidence of Coverage (EOC) document for detailed information on appeal rights and procedures. Before 2018, Medicare Advantage and Part D plans were required to mail the 140+ page Evidence of Coverage booklets to all current plan enrollees in September for plan changes for the following year, and to new enrollees when their plan became effective. Now plans are only required to post the Evidence of Coverage on their website by October 15. If you'd like a copy of the EOC, you can call your plan and request they mail one to you.

Coverage Determinations

A coverage determination is a plan sponsor's decision whether to cover a prescription drug or reimburse you for a prescription drug you paid for. A plan sponsor's decision to grant an exception to cover a drug not on the formulary is a type of coverage determination. (See next section for more information on Exceptions.)

If you are not able to get your prescription drug filled at a pharmacy under your Medicare Part D plan, the pharmacy is required to give you a standardized written notice. The notice explains how to contact your plan to ask them to consider covering the prescribed drug. In technical terms, you are requesting a "Coverage Determination." If the plan's Coverage Determination is unfavorable and denies coverage of the prescribed drug, you may appeal.

You may request a "Coverage Determination" from your plan in the following situations:

- If your drug is subject to prior authorization, which means the plan wants your doctor to explain why he/she prescribed the drug.
- If your drug is subject to step therapy, which requires you to try another drug (usually a lower cost alternative) before the plan decides whether to cover the prescribed drug.
- If your drug is subject to quantity limits and your prescription exceeds the limit.
- If the plan denies coverage of a drug even though it is in the formulary.
- If you paid for a prescription and want the plan to reimburse you.

You, your doctor, family member, or other authorized representative can contact your plan to request a coverage determination. You can call or write a letter to make this request. Once the request is received, the plan must respond within a certain time.

Expedited Request: The plan has 24 hours to respond to an "expedited request" for a coverage determination. Your doctor may request an expedited coverage determination if he/she tells your plan that your life or health will be seriously jeopardized by waiting for a standard decision. The plan must automatically process an expedited request from a doctor.

Note: You will not get an expedited decision if you've already paid for and received the drug.

You may make an expedited request without your doctor's support, but the plan is not required to automatically process it as an expedited request. It may deny the expedited request and process it as a standard request. Thus, instead of responding within 24 hours, the plan may respond within 72 hours. If the plan denies your request to expedite a coverage determination, you may file a grievance or resubmit the expedited request with your doctor's support.

The plan must respond to an expedited request within 24 hours by telephone. It must also mail you a written expedited coverage determination letter within 3 calendar days after it verbally informs you of its decision.

If the plan does not respond to your expedited request within 24 hours, it must forward your request to the Independent Review Entity (IRE) within the next 24 hours. More information about the IRE is below.

Standard Request: The plan has 72 hours to respond to a standard request for coverage of a prescription drug that has not been received. For a request for reimbursement of a prescription drug already received, the plan has 14 days to respond.

Exceptions

When requesting an exception, you must have a supporting statement from your doctor. Situations where you may request an exception include:

- Your prescribed drug is not on the plan's formulary. You may request the plan to cover the drug with your doctor's supporting statement explaining that the drugs on the formulary would not be as effective as the prescribed drug and/or would have adverse effects.
- Your prescribed drug is in the formulary but in a non-preferred tier at a higher copayment. You may request your plan to cover the prescribed drug at a lower copayment with your doctor's supporting statement explaining that the drugs in the lower cost-sharing tier would not be as effective as the prescribed drug and/or would have adverse effects. Please note that plans are not required to approve such requests for drugs in a specialty tier.
- You believe that a coverage rule (such as prior authorization) should be waived.
- You disagree with your plan's "at-risk determination" under a drug management program that limits your access to frequently abused drugs, such as opioids.

Once an exception is granted, it remains in effect for the calendar/plan year (as long as your doctor prescribes it). If you renew your enrollment in the same Medicare drug plan at the end of the year, you may be required to submit a new exception request for the next year.

If the drug plan does not grant your request, the plan must notify you (and your doctor, if he or she is the one who made the exception request) in writing within 72 hours if you submitted a standard request, or within 24 hours if you submitted an expedited request. It must explain the reason for the denial and how to continue in the appeals process.

Appeals

If the plan issues a coverage determination that is not in your favor, you can appeal that decision. Information about the plan's appeal procedures is in the Evidence of Coverage. This information is on your plan's website. Keep the link to this information handy in case you need it later. You can also call your drug plan for this information and have them mail it to you.

There are 5 levels of appeal available, outlined below.

Step 1: Redetermination by Plan

The first step in the appeals process is through your drug plan. You must request this appeal within 60 calendar days from the date of the coverage determination (though the time period can be extended if you can show good cause

why you filed late). You, your authorized representative, or your doctor must file a request in writing unless your plan accepts telephone requests.

Your request will be expedited if your plan determines, or if your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard decision. Once your plan receives your request, the plan has 14 days (standard) or 72 hours (expedited) to notify you of its decision.

Step 2: Reconsideration by Independent Review Entity (IRE)

If the plan's Redetermination is not in your favor, you may request the next level of review by an Independent Review Entity (IRE). You must make a standard or expedited request within 60 days from the date of the decision. Your request will be expedited if the IRE determines, or if your doctor states that your life or health will be seriously jeopardized by waiting for a standard decision. The request must be in writing and sent directly to the IRE.

Once the request is filed, the IRE has 14 days (standard) or 72 hours (expedited) to notify you of its decision. The IRE is required to ask your prescribing doctor for his or her opinion about the appeal and must include a written account of the doctor's input in the redetermination documentation.

Note: Your prescribing doctor also can request an independent review on your behalf without having to complete an appointment of representative form. In this case, your prescriber must notify you about the IRE request, and the IRE will then notify the prescriber of its decision.

The IRE in California is called Maximus Federal Services and more information can be found on their website: medicarepartdappeals.com.

Step 3: Hearing with an Administrative Law Judge (ALJ)

If the IRE's Reconsideration is not in your favor, you can request a hearing with an ALJ from the federal Department of Health and Human Services. You must request the hearing in writing within 60 days of the IRE decision.

You must send the request to the entity specified in the IRE's reconsideration notice. To receive an ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount. (You may be able to combine claims to meet the minimum.) In 2023, the minimum is $180. (This amount may change each year.) The IRE's decision should include this amount.

Once the request has been received, the ALJ generally has 90 days to make a decision, though this timeframe can be extended for several reasons, including submission of new evidence or if you request an in-person hearing. Hearings are generally done over the phone or through video-conference.

There are several ways to meet the required dollar amount:

- Use the projected value of the drug (or drugs) in question over the course of the calendar year;
- Combine 2 or more of your appeals; or
- Get a group of people together who are all in your same plan and are filing an appeal for the same drug. Appeal amounts can be combined this way to meet the required dollar amount.

Step 4: Review by the Medicare Appeals Council (MAC)

If the ALJ's decision is not in your favor, you may request a review by the MAC. You must make the request in writing to the MAC within 60 days from the date of the notice of the ALJ's decision. The MAC generally reviews evidence in the record, and no hearing is involved. The MAC has 90 days to make a standard decision

or 10 days to make an expedited decision after receiving the request.

Step 5: Review by a Federal Court

If the MAC's decision is not in your favor, you may request a review by a Federal Court. You must make the request in writing within 60 days of the date of the notice of the MAC's decision.

You must send your request to the entity specified in the MAC's decision notice. To receive a Federal Court review, the projected value of your denied coverage must meet a minimum dollar amount, which is $1,850 in 2023. The MAC's decision will include this amount.
Note: You should consider seeking legal advice before appealing to an Administrative Law Judge, the Medicare Appeals Council, or Federal Court.

Complaints/Grievances

If you have a complaint about your Medicare drug plan that doesn't involve coverage or payment, you have the right to file a complaint (also called a "grievance").

Complaints can come from dissatisfaction with any aspect of a drug plan's operations, activities, or behavior. Examples of why you might file include:

- You have to wait too long for your prescriptions;
- The plan did not make a decision within the required timeframes;
- The plan denied your request for an expedited coverage determination; and/or
- The plan did not provide customer service in your preferred language.

You should file your complaint, orally or in writing, within 60 days of the event that led to the complaint. The plan must notify you of its decision within 30 days after receipt of the complaint/grievance, except if your complaint is about the plan denying your request for an expedited coverage determination. In this exception, the plan must respond within 24 hours. In other grievances, the 30-day timeframe can be extended at your request or if the plan can show that a delay would benefit you. If the plan doesn't take care of your complaint, call 1-800-MEDICARE (or 1-800-633-4227).

If you complain about the quality of care, the plan must respond to you in writing, and must include a description of your right to file a written complaint.

Quality of care complaints can also be filed with Livanta, the Quality Improvement Organization (QIO) in California, at 1-877-588-1123, or 1-855-887-6668 (TDD for the hearing impaired). See Livanta's website: https://www.livantaqio.com/en.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.

Note: Online access to all CHA fact sheets on Medicare and related topics is available for an annual subscription. See cahealthadvocates.org/fact-sheets/.